Promoting Administrative Simplification through ERA and EFT Adoption: *An Industry Call to Action*

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White Paper

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Executive Summary

Promoting administrative simplification through ERA and EFT Adoption: *An Industry Call to Action*

Administrative simplification is a team sport and in that light, the Healthcare Administrative Technology Association (HATA), the national practice management association, has released an *Industry Call to Action* to encourage all stakeholders to collaboratively work with practice management systems (PMS) to address and encourage provider adoption and vendor/payer HIPAA compliance of electronic standard transactions

With the release of this Call to Action, HATA will be working toward the creation of a nationwide public education campaign to: 1) raise provider awareness of the benefits of electronic remittance advice (ERA) and Electronic Funds Transfer (EFT); 2) increase awareness of and remove the barriers to provider adoption; and, 3) increase provider adoption.

HATA will take the following steps as part of this Call to Action:
- Share industry best practices of increasing ERA and EFT reconciliation and improving the efficiencies of an automated end to end workflow process.
- Convene an industry ERA/EFT summit to identify strategies to encourage industry adoption of the ERA and EFT standards and supporting CAQH CORE operating rules.
- Partner with National Automated Clearing House Association (NACHA) to raise awareness of the ways banks and PMS can collaborate to increase ERA and EFT matching.

A recent HATA ERA/EFT survey results shined a light on areas for discussion, which include the need for:
- An easy identification of the vast numbers of payers that provide ERA and EFT, as well as an easy sign up process to assist PMS to encourage their users to sign up for ERA and EFT. Less than half of the survey respondents' message to their clients to encourage them to sign up for EDI standard transactions, including ERAs and EFTs.
- Reduction of PMS automated workflows that are disrupted and require manual intervention. The following issues with the ERA were identified as disrupters to the automated workflow 50% of the time:
  - Re-adjudicated claims (reversal and correction) with immediate overpayment recovery
  - Balance forward
  - Overpayment recovery without reversal and correction in the ERA
  - Split services
  - Managed care encounters

- Automated reconciliation between the ERA and the EFT addendum (CCD+) received from the bank upon request is optimal for the provider. This gives the provider assurance that payment has been received for the claims in the ERA, so the ERA information can be posted to the PMS. Of the survey respondents 45% have this capability and of the 45%, approximately 42% of the EFT files are received.

There appears to be a significant manual workflow process still being deployed as part of the ERA EFT reconciliation. Automating this manual workflow could reduce A/R days and costs even further. HIPAA standards and operating rules require the payer to provide the transactions and reassociation information in a standard format. Providers and their PMS vendors should take advantage of this requirement to collaborate with payers and clearinghouses to facilitate automated workflows.

Promoting administrative simplification through ERA and EFT Adoption: An Industry Call to Action

The Healthcare Administrative Technology Association (HATA) is a strong supporter of leveraging electronic standard transactions as a vehicle to improve the claims revenue cycle overall and electronic payment specifically to produce a more efficient healthcare delivery system. To better achieve increased automation through electronic funds transfer (EFT) and electronic remittance advice (ERA), and the value it presents for payers and providers, both must commit to actively using these standards. As facilitators of these transactions, practice management system (PMS) vendors are a critical component in this process. HATA has initiated this call to action to encourage payers, providers and PMS vendors to work together to make the promise of electronic payment simplification a reality.

Effective representation of key stakeholders within the healthcare industry is crucial to the advancement of the industry. For too long, the healthcare administrative technology market segment including PMS vendors has not been heard in the administrative simplification debate. Until recently there has been no formal organization to represent the healthcare administrative technology industry. HATA was formed to provide this forum to address issues and facilitate solutions through a collective voice.

PMS and other administrative technology vendors deliver the capabilities to streamline the provider revenue cycle. This includes not only EFT and ERAs but also the sending and receiving of electronic claims, insurance eligibility verifications, claim status and other transactions to facilitate automated end to end workflow. Providers need a process that is as fully automated as possible to ensure adoption.

As a professional association that represents PMS and other administrative revenue cycle vendors, HATA is committed to assisting its members implement these standard transactions to meet business needs as required, and encourage payers to provide PMS the necessary information to meet the provider's business needs, not just sending standard transactions that meet the syntactical compliance currently required under HIPAA. We recognize that accurate and complete information is needed to ensure provider workflow is free of cumbersome steps and as fully automated as possible in order to ensure adoption. When this occurs, payers and providers will realize the vast resource and cost savings from complete claims revenue cycle automation.

HATA's commitment on behalf of PMS is to raise industry awareness of the increased efficiencies available with complete adoption of and automation of the ERA/EFT transactions by all stakeholders to achieve automated end to end workflow processing. Administrative simplification is a team sport and in that light, HATA has released an **Industry Call to Action** to encourage all stakeholders to collaboratively address and encourage provider adoption and vendor/payer HIPAA compliance.

With the release of this Call to Action, HATA will be working toward the creation of a nationwide public education campaign to: 1) raise provider awareness of the benefits of ERA and EFT; 2) increase awareness of and remove the barriers to provider adoption; and, 3) increase provider adoption of electronic remittance advice (ERA) and Electronic Funds Transfer (EFT).

HATA will take the following steps as part of this Call to Action:

- Partner with National Automated Clearing House Association (NACHA) to raise awareness of the ways banks and practice management systems can collaborate to increase ERA and EFT matching.
- Share industry best practices of increasing ERA and EFT reconciliation and improving the efficiencies of an automated end to end workflow process. The identification of vendor best practices and successful ways to increase provider outreach by the healthcare industry could lead to increased provider adoption of ERA and EFT standard transactions and provider satisfaction with their revenue cycle solutions.
- Convene an industry ERA/EFT summit to identify opportunities to communicate to: providers the benefits of ERA and EFT; payers the need to send transactions that contain the information necessary to meet the business needs of the provider and automate the ERA and EFT posting; clearinghouses and PMS the need to pass the information within a streamlined workflow, and also to identify strategies to encourage industry adoption of the ERA and EFT standards and supporting CAQH CORE operating rules. http://www.caqh.org/Host/CORE/EFT-ERA/EFTERA_CompleteRuleSet.pdf

Survey Results

From September 8, 2014 to October 31, 2014 HATA conducted an online survey of 30 PMS vendors to better understand the automation capabilities currently available to providers to receive ERA and EFTs, barriers to provider adoption of ERA/EFT, and potential solutions to these barriers in providing complete ERA/EFT automation.

The HATA ERA/EFT survey represented 30 PMS respondents who provided 15 to 28 responses per question. The responses clearly conveyed what automation is possible today for providers who choose to enroll in and receive electronic remittance advice and electronic funds transfer transactions. The responses also clearly convey the challenges faced by PMS from not only non-compliant transactions, but those transactions that do not supply all sufficient information needed to satisfy the providers' business needs.

Payers and clearinghouse are considered HIPAA covered entities for commercial and governmental lines of business and required to be able to send and receive standard HIPAA transactions & code sets (TCS).

Survey responders indicated that **approximately 54%** of payers provide the required information in the HIPAA TCS and CAQH CORE compliant ERA standard transaction **over 80% of the time**, which leaves 46% that comply less than 80% of the time. Noncompliant transactions require PMS vendors to focus resources on creating payer-specific customizations for each of these transactions, distracting PMS vendors from focusing on streamlining and upgrading the current user experience. When PMS cannot pass on the information needed by the provider for the majority of the payers that send ERAs, the incentive for the provider to continue to use the information provided by the PMS from a standard transaction is reduced. Providers then return to calling the payer for the information, which is costly for both the provider and payer. Maintaining multiple workflows for various payers is time intensive for the provider and difficult and costly for the PMS to provide. Only by providing the standard information needed to satisfy the business need within the provider workflow will adoption provide the administrative simplification promised by HIPAA and the Accountable Care Act.

When validating the HIPAA standard electronic remittance advice transaction (ASC X12 835), PMS most often check the Transaction structure/Syntax and balancing.   In contrast, verifying that the less obvious requirements (CARC/RARC combination is valid per the CORE Operating Rule; Claim Submitter's Identifier is valid and matches the original claim; and the submitted procedure code is valid and matches the submitted code) are met occurs much less frequently—only 10% of the time.. There is opportunity to increase validation that the information received on the ERA is accurate. However, providers and their PMS need to be committed to act on the information they receive from these edits.

Thirty one percent of survey responders have payer fee schedules and are able to provide an automated allowed amount validation, 27% have some payer fee schedules and provide manual validation, while 42% don't have payer fee schedules at all.   Payers are encouraged to provide downloadable fee schedules that can be uploaded into their PMS and in turn PMS systems are encouraged to provide the ability for providers to maintain their numerous fee schedules and validate the ERA allowed amount against those tables.

Automated reconciliation between the ERA and the EFT addendum (CCD+) received from the bank upon request is optimal for the provider. This gives the provider assurance that payment has been received for the claims in the ERA, so the ERA information can be posted to the PMS. Without automated reconciliation, the provider must manually reassociated the EFT and ERA, delaying the process. Of the survey respondents 45% have this capability and of the 45%, approximately 42% of the EFT files are received. Of the survey respondents 45% have this capability and of the 45%, approximately 42% of the EFT files are received in an automated fashion from the provider's bank into the PMS for re-association with ERA. 25% of the EFT files are manually downloaded from bank then imported into PMS by user and 33% use a third party partner relationship that performs the EFT file retrieval and matching capability within Provider's PMS.

The majority of survey respondents (75%) indicated they have the ability to receive ERA files in an automated fashion from a Clearinghouse/Payer into PMS. The remaining 25% either

manually download the ERA and then import into the PMS or utilize a third party relationship to deliver this retrieval and matching capability.

There appears to be a significant manual workflow process still being deployed as part of the ERA EFT reconciliation. Automating this manual workflow could reduce A/R days and costs even further. HIPAA standards and operating rules require the payer to provide the transactions and re-association information in a standard format. Providers and their PMS should take advantage of this requirement to facilitate automated workflows.

Send/Receiving Transaction

PMS systems may receive standard transactions through many different avenues. The majority of survey respondents indicated that they receive transactions from multiple clearinghouses and/or sent direct to or received direct from a payer. Other responses included accepting transactions from a user preferred clearinghouse and PMS' own designated clearinghouse.

The workflow that is used to post the standard ERA varies by PMS and user preference. The most common (48%) approach is to automatically post multiple payers. Other options include: upon client indication, system posts multiple payers at once (33%), upon client indication, system posts by payer (29%), manually post (14%) and approximately 5% do not have posting capabilities.

Overwhelmingly 89% of survey respondents display a proprietary readable format of the 835. In addition, 84% of these formats by display the specific CARC/RARC descriptions and CORE business scenarios. Approximately 6% provide the ERA EDI Format, which is intended to be machine readable, and another 6% do not provide a readable format, requiring a higher degree of sophistication from the provider to gain advantage from the standard ERA transaction.

62% of the survey respondents either apply commercial, proprietary or a combination of front end edits to ensure the ERA standard transactions being sent from their system is both HIPAA and CAQH CORE operating rule compliant.

In turn, survey respondents take action when a noncompliant ERA is received from a payer or other entity by: 1) notifying user (36%); 2) going direct to the payer by contacting the Payer's EDI Help desk to alert payer and request changes to be made by payer (23%); 3) return a negative acknowledgment (5%); and/or 4) verify if suspected noncompliance is accurate with ASC X12 through a Request For Interpretation (5%). Many survey responders take one or more action steps to address non-compliant transactions. All PMS are encouraged to enable transaction validation edits to ensure the receipt of compliant transactions and in turn raise awareness to a sender when a noncompliant transaction is received. All trading partners should collaborate to resolve transaction and compliance issues.

The majority of survey respondents apply business rule logic to the payment message codes that are reported on the 835, which include the CARCs and RARCs. Sixty four percent provide a

complete set of business rules to automate the denial management workflow, while 14% apply CAQH CORE operating rules.

Less than half of the survey respondents engage in messaging to their clients to encourage them to sign up for EDI standard transactions, including ERAs and EFTs. Those who provide routine messaging to their clients, typically provide it weekly.

The majority of survey respondents indicated their PMS is focused on providing automated workflows and provides the capabilities listed below. However, keep in mind that each PMS capabilities vary and potential users are encouraged to ask each vendor how they handle the following automated workflow processes.

Percentage of time the majority of the respondents reported they used an automated workflow process for handling:
- Primary claims containing standard reductions (deductible, co-pay, co-insurance, exceeds fee schedule) over 89%
- Primary claims containing non-covered services over 74%
- Rejected primary claims requiring additional information over 68%
- Secondary claim payment posting over 60%
- Automated submission to secondary/tertiary payers over 60%
- Automated triggering of patient bills after all payers respond over 60%
- Re-adjudicated claims (reversal and correction) with additional payment over 70%
- Re-adjudicated claims (reversal and correction) with immediate overpayment recovery over 50%
- Re-adjudicated claims (reversal and correction) with delayed overpayment recovery over 70%
- Balance forward over 50%
- Overpayment recovery without reversal and correction in the ERA over 50%
- Split claims over 70%
- Split services over 50%
- Bundled procedures over 70%
- Unbundled procedures over 60%
- Managed care encounters over 50%
- Miscellaneous Provider Level Adjustments over 70%

The majority of the respondents have the capability to automatically post ERAs that were converted from a paper EOB to ERA. Fifty percent are able to auto-post without requiring any manual review, 29% can auto-post, while 21% indicated that the accuracy of the data received on the converted ERA prevents auto-posting.

Additional scenarios, many noncompliant with HIPAA that were mentioned within the survey, impede the workflow process for EFT/ERA Re-association includes:

- There needs to be a standard way to export necessary data that would allow easy EFT re-association with the ERA.
- Payer sends multiple payments but only one is reported on the ERA
- Payment Type identifier mismatch issues occur, such as ACH vs. CHK vs. NON with EFT numbers, check number
- The complete Re-association (TRN Segment) is not contained in the EFT files.
- Payment defaulting to single use credit cards without provider input
- Payers that at either the claim or service level, especially with secondary payments
- Payers that do not return the REF*6R as unique number or at all.
- Payer's incorrectly sending adjustment information Payer's that don't use the correct claim status indicator in the ERA (CLP02) to identify their COB order.
- ERA's are received that are out of balance. While this is noncompliant with HIPAA, the majority of PMS system automatically post portions of an ERA without posting all (i.e. post payments but not adjustments in situations where files are out of balance)?

Over 70% of the time, respondents indicated their Providers accept the healthcare EFT standard via ACH for claims reimbursements other than Medicare.

Conclusion

The 2013 CAQH Efficiency Index reported Electronic **claim remittance advice and posting and receiving of payments** showed the lowest level of adoption in the study (53 percent), with more than 10 percent being transmitted both electronically and via paper. We realize adoption is increasing and great strides have been made by PMSs to provide an end to end ERA EFT reconciliation and payment process, more work needs to be done. An automated end to end workflow that includes automated ERA EFT reconciliation would bring the necessary provider adoption to drive ROI to all participating stakeholders.

Additionally, there is clearly a need for industry education. While the industry has promoted ERA and EFT widely, many stakeholders have not been able to keep up with the required changes. All stakeholders in addition to PMS have a responsibility to their customers to keep them updated on these required changes.

Recognizing that smaller practices may not be focused on the nuances of finding areas to reduce cost, such as signing up for ERA/EFT, raises the need for increased education from PMS, as well as the industry at large.

Receiving noncompliant transactions from payers and vendors drives cost up for PMS. PMS are encouraged to work with their trading partners to increase the use of HIPAA compliant transactions. Noncompliant transactions increase costs for PMS and all related stakeholders due to the time and effort required to perform workarounds, instead of focusing resources to enhance the automated end to end workflow streamlined user experience for providers.

There appears to be a significant manual workflow process still being deployed as part of the ERA EFT reconciliation.   HIPAA standards and operating rules require the payer to provide the transaction and re-association information in a standard format. Providers and their PMS should take advantage of this requirement to facilitate automated workflows.

All stakeholders, including PMS and other technology vendors, payers and providers must join forces to ensure an automated end to end revenue cycle can be delivered to providers. This can occur by ensuring standard transactions pass on the information needed to meet the business needs, which allows for process automation.

DISCLAIMER:

Appendix One

<u>Background</u>

Formal representation and input of key stakeholders on meaningful issues within the healthcare industry is crucial to the advancement of the industry. For too long, the healthcare administrative technology market segment including practice management systems has not been sufficiently represented or heard in the administrative simplification debate.   Until recently there has been no formal organization to represent the healthcare administrative technology industry. The Healthcare Administrative Technology Association (HATA) was formed to provide this forum to address issues and facilitate solutions through a collective voice.

PMS are business associates of providers that deliver a software solution to streamline administrative processes.   PMS systems are not subject to HIPAA requirements around transactions and code sets or operating rules as they are not considered covered entities, unlike the HIPAA privacy rules, which were applied to business associates through the HITECH act. PMS are built to carry out the automation of the provider revenue cycle and are expected to provide efficiencies to the provider practice in the sending and receiving of HIPAA standard transactions that are compliant with the CORE Operating Rules.

In 2014, the CAQH CORE Phase III operating rules for ERA/EFT went into effect. The ERA is the payment explanation sent from the payer to the provider, which is critical to reconciling patient and payer financial responsibility and posting to the provider's accounts receivable system to either close an account or identify what action needs to be taken to ensure appropriate payment is received from either or both the patient and payer.

ERAs contain standard HIPAA Claims Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC), which provide the payer's explanation for the claim adjudication and adjustments made to a payment on a claim.   When applied accurately, these codes provide an opportunity to automate the processing and application of the payer claim payment to the provider.

CAQH CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Operating Rules identifies specific combinations of CARC and RARC codes, along with Claim Adjustment Group Codes, within the framework of four specific business scenarios. The great variability in the mapping and combinations of codes used by payers in the past to explain payment adjustments on ERAs has resulted in interpretation issues for providers. The CARC/RARC usage combinations takes the first step toward facilitating an automated workflow by requiring a concrete and predictable message for that select set of scenarios, thereby allowing providers to set up rules to automate actions based upon the

combinations of codes. Consistent use of these codes by all payers will result in significant administrative simplification.

EFT is an automated payment method, similar to direct deposit payroll payment many use today. Instead of sending a check, an electronic funds transfer is made between the payer's designated bank/account and the practice's designated bank/account. The ERA/EFT Operating Rules require increased transparency on the ERA and clarify the appropriate placement of the Re-association Trace Number, a tracking number that is required to be placed on the ERA and EFT to enable matching of the appropriate documents. This is important, as ERAs are typically transmitted from the payer, either directly or through designated intermediaries, to the providers or their PMS systems, while the EFT is transmitted from the payer, through its designated financial intermediary to the provider's bank. The EFT addendum provided by the Bank upon provider request provides the means to match the EFT to the ERA within PMS systems.

The national standard under HIPAA for the ERA is the ASC X12N Health Care Claim Payment/Advice (835), guide 005010X221. The national standard under HIPAA for EFT is the NACHA Cash Concentration or Disbursement Plus Addenda (CCD+).

About HATA

The Healthcare Administrative Technology Association (HATA) is a new association formed to be the strong, singular voice for the PMS industry to have influence on regulation and legislation, and to protect and promote our core values. Membership in HATA will provide you with tools you need to expand and build upon your client base, give you immediate access to industry education focused on PMS< enable you to be part of a bigger group to influence regulation and legislation, improve your efficiency with access to exclusive vendor resources, collaborate with your peers, and be part of one strong voice for national PMS representation. For more information, visit our website at http://www.hata-assn.org or call Tim McMullen, CAE at 844-440-4282.

Appendix Two

Additional Resources

Electronic Payments & Statements (EPS)
Providers can enroll and manage payments from multiple payers leveraging a single, secure authentication process. EPS shortens the revenue cycle with payments sent directly to the provider's bank account(s). 835 files are available for auto-posting and user-friendly electronic remittance advices (ERA) are online for manual payment posting.

Access more information at https://www.optumhealthfinancial.com/physicianshealthcareproviders/electronicpaymentsstatements/

EnrollHubTM - EFT and ERA Enrollment Simplified. Increasing adoption of electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment continues to challenge healthcare organizations. EnrollHub is a CAQH Solution that simplifies and streamlines the EFT and ERA enrollment processes for providers and payers - helping improve administrative efficiency and save time as it allows providers to enroll for multiple providers.

View the CAQH and NACHA Webinar: Accelerating EFT Adoption with Providers. Access http://www.caqh.org/eft_enrollment.php for more information.

American Medical Association & Medical Group Management Association Resources
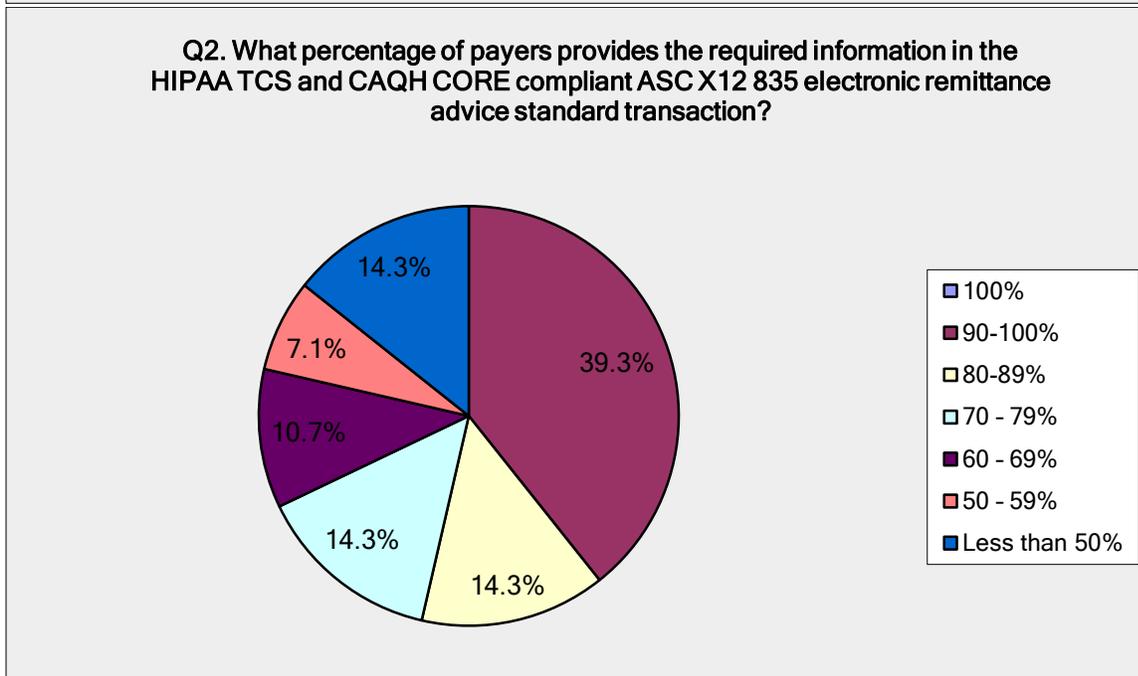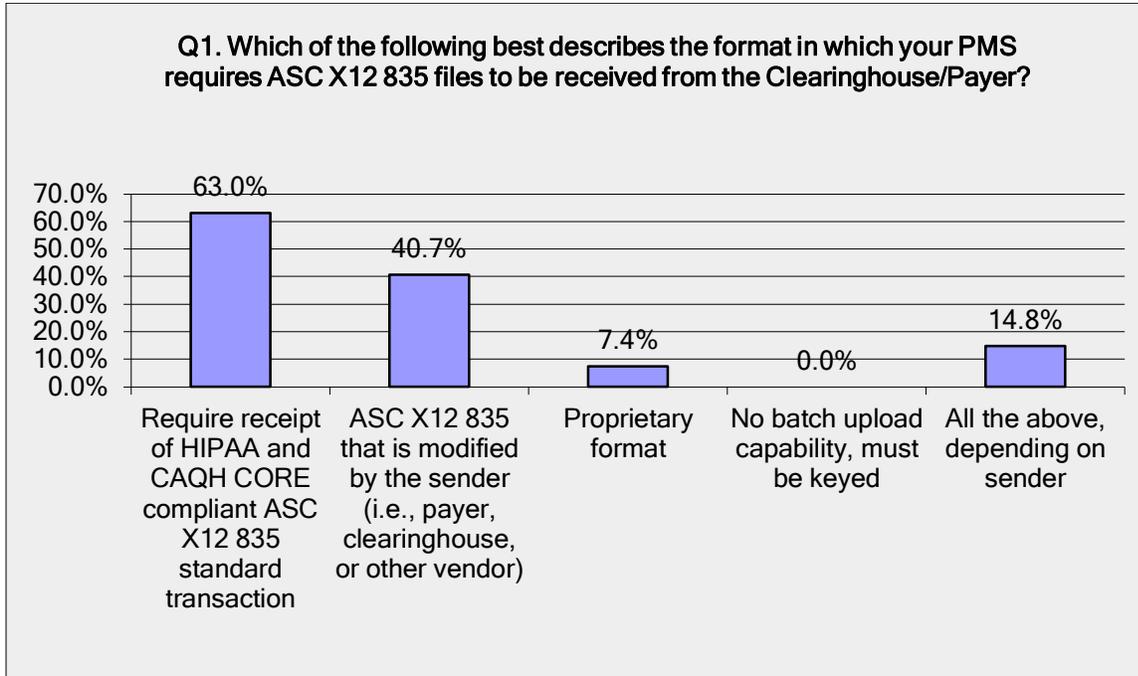AMA & MGMA Selecting a Practice Management System Toolkit (www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/pms-toolkit.page?)
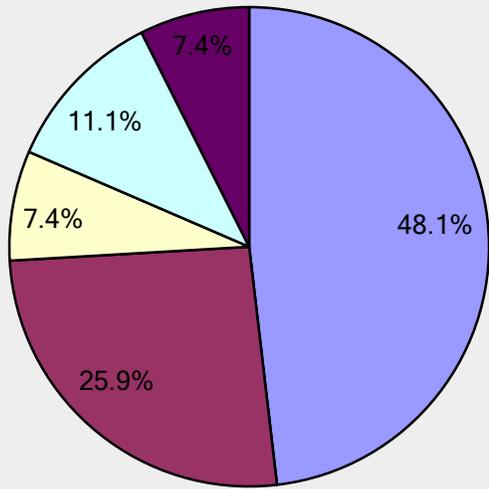AMA EFT Toolkit (http://www.ama-assn.org/go/EFT)
AMA ERA Toolkit (http://www.ama-assn.org/go/ERA)

Appendix Three

Data Graphs

Q1. Which of the following best describes the format in which your PMS requires ASC X12 835 files to be received from the Clearinghouse/Payer?

Category	Percentage
Require receipt of HIPAA and CAQH CORE compliant ASC X12 835 standard transaction	63.0%
ASC X12 835 that is modified by the sender (i.e., payer, clearinghouse, or other vendor)	40.7%
Proprietary format	7.4%
No batch upload capability, must be keyed	0.0%
All the above, depending on sender	14.8%

Q2. What percentage of payers provides the required information in the HIPAA TCS and CAQH CORE compliant ASC X12 835 electronic remittance advice standard transaction?

| Category	Percentage
100%	—
90-100%	39.3%
80-89%	14.3%
70 – 79%	14.3%
60 – 69%	10.7%
50 – 59%	7.1%
Less than 50%	14.3%

## Q3. In validating the 835, which of the following do you check?

Legend:
- Transaction structure/Syntax
- Balancing
- Verify that the CARC/RARC combination is valid per the CORE Operating Rule
- Verify Claim Submitter's Identifier
- Verify submitted procedure code

Pie chart values: 7.4%, 11.1%, 7.4%, 25.9%, 48.1%

Q4. Do you validate the reported allowed amount against payer or other applicable fee schedule?
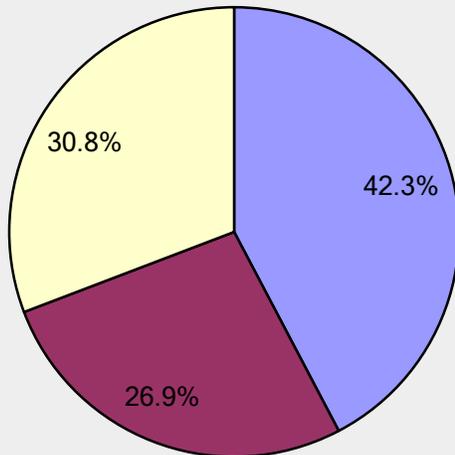

Legend:
- Don't have payer fee schedules
- Have some payer fee schedules, but validation is manual
- Have some payer fee schedules and provide automated allowed amount validation.

Pie chart values: 30.8%, 42.3%, 26.9%

Q 6. Does your system offer automated reconciliation of the TRN segment between the CCD+ received from a provider's bank and the 835 (reassociation of the CCD+ and the 835)?

45.5%

54.5%
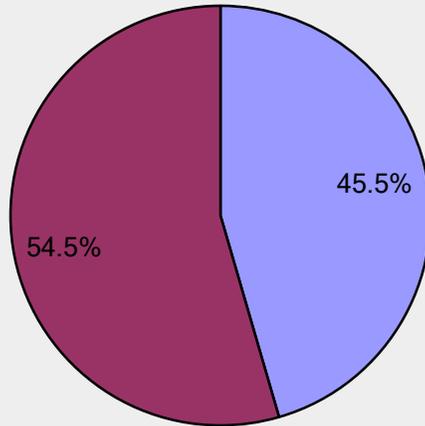
- ☐ Yes
- ■ No

Q7. What is the method your PMS uses to retrieve the EFT CCD+ files for re-association with the ASC X12 835?
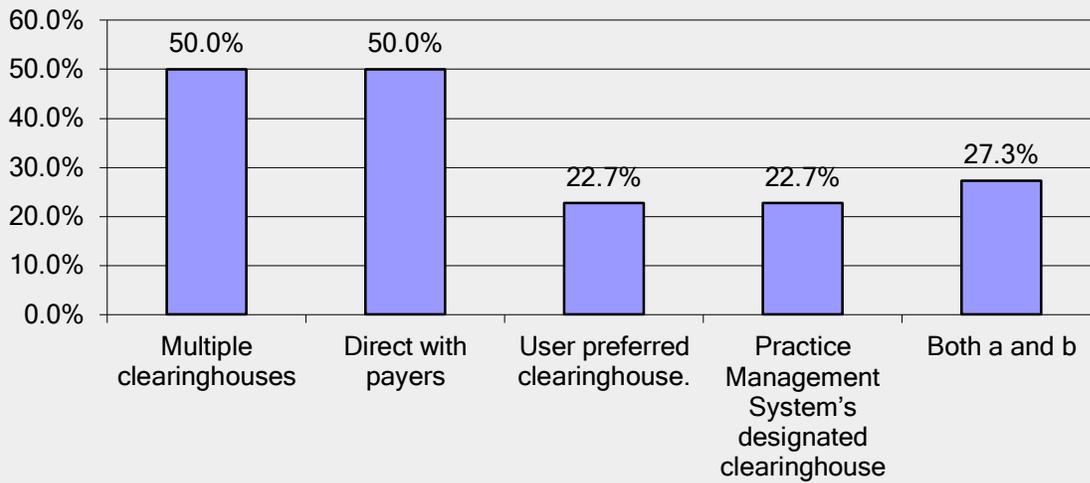
33.3%

41.7%

25.0%
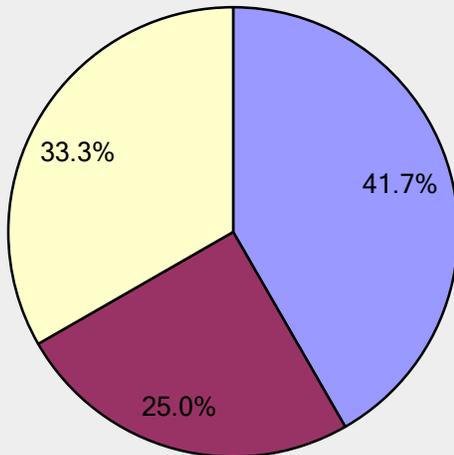
- ☐ EFT files received in automated fashion from bank into PMS for re-association with ASC X12 835

- ■ EFT files manually downloaded from bank then imported into PMS by user

- ☐ Third party partner relationship that performs the EFT file retrieval and matching capability within Provider's PMS

Q8. What is the method your PMS uses to retrieve the ASC X12 835 file for re-association with the EFT file?
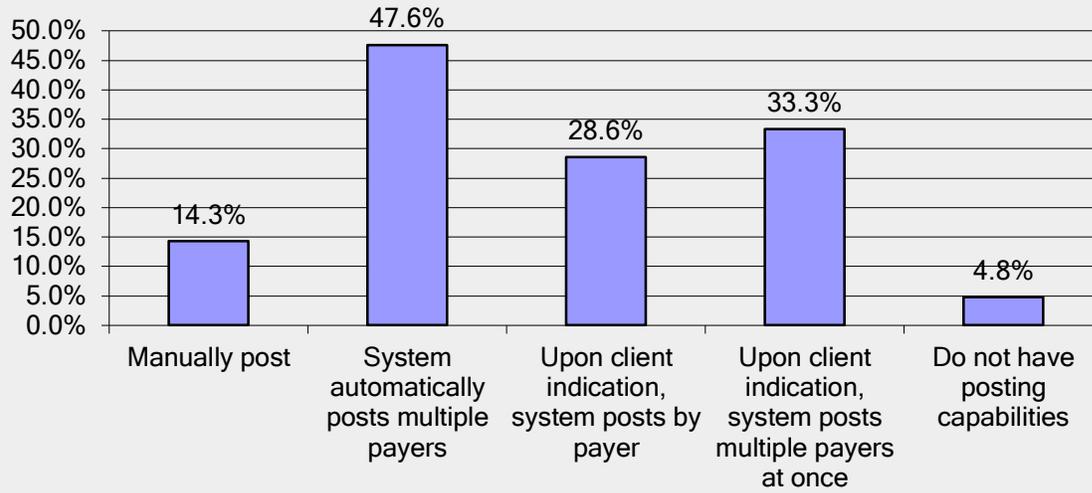
10.0%

15.0%

75.0%
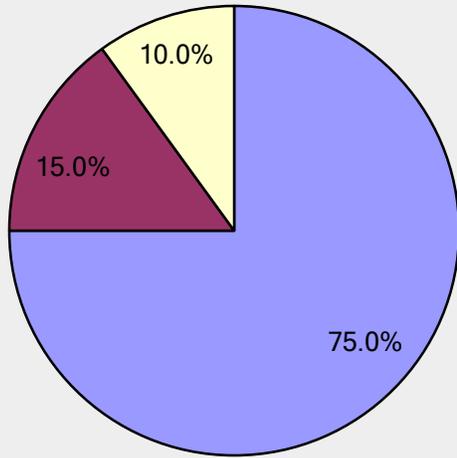
- 835 files received in automated fashion from Clearinghouse/Payer into PMS

- 835 files downloaded from Clearinghouse/Payer then imported into PMS

- Third party partner relationship that performs the 835 file retrieval and matching capability within Provider's PMS
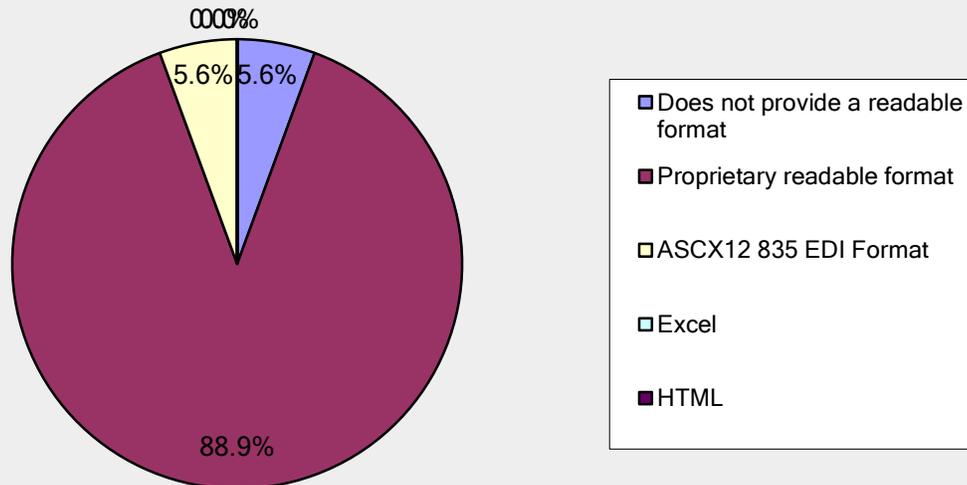
Q9. Does your Practice Management System send/receive transactions through:

Category	Percentage
Multiple clearinghouses	50.0%
Direct with payers	50.0%
User preferred clearinghouse.	22.7%
Practice Management System's designated clearinghouse	22.7%
Both a and b	27.3%

Q10. Which of the following best describes the workflow that is used to post the standard ASC X12 835 electronic remittance advice?
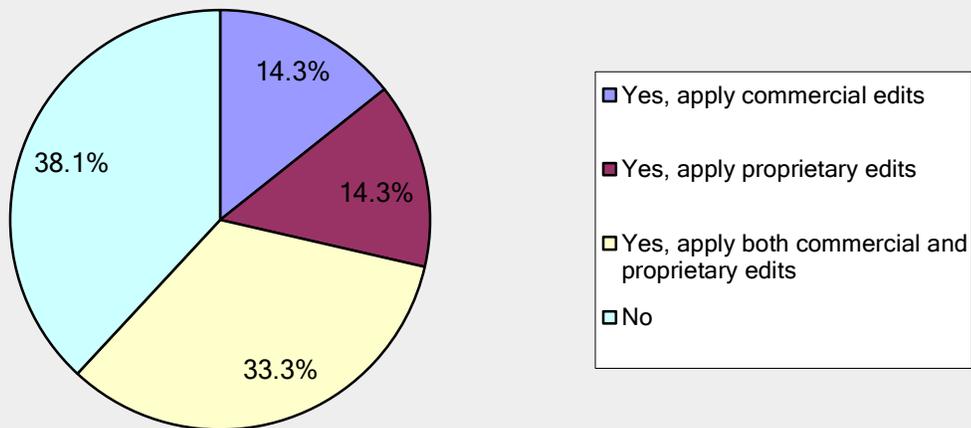

Category	Percentage
Manually post	14.3%
System automatically posts multiple payers	47.6%
Upon client indication, system posts by payer	28.6%
Upon client indication, system posts multiple payers at once	33.3%
Do not have posting capabilities	4.8%

Q11. What format does your PMS display the ASC X12 835 Electronic remittance advice information?

- Does not provide a readable format — 5.6%
- Proprietary readable format — 88.9%
- ASCX12 835 EDI Format — 5.6%
- Excel — 0.0%
- HTML — 0.0%

Q12. If your PMS system displays the ASC X12 835 remittance advice information in a human-readable format, does it comply with the CORE Operating Rules by displaying the CARC/RARC descriptions and CORE business scenarios?

15.8%

84.2%

Yes
No
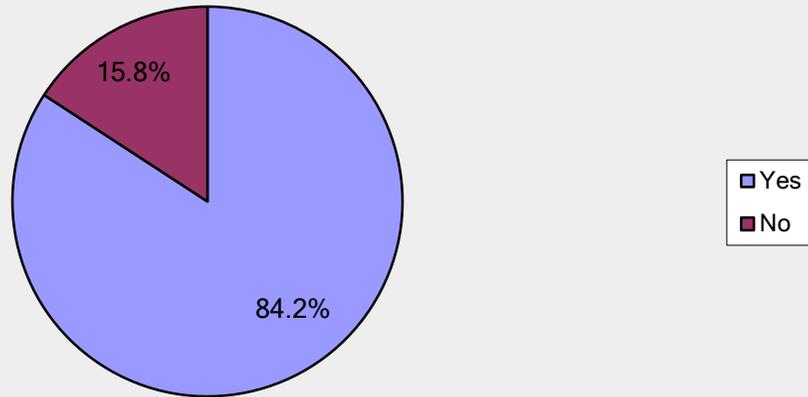
Q13. Does your system apply front-end edits to ensure ASC X12 standard transactions are HIPAA and CAQH CORE operating rule compliant?


14.3%

14.3%

38.1%

33.3%

Yes, apply commercial edits

Yes, apply proprietary edits

Yes, apply both commercial and proprietary edits

No

Q14. What action does your PMS system take for situations where the ASC X12 835 transactions are found to be non-compliant?
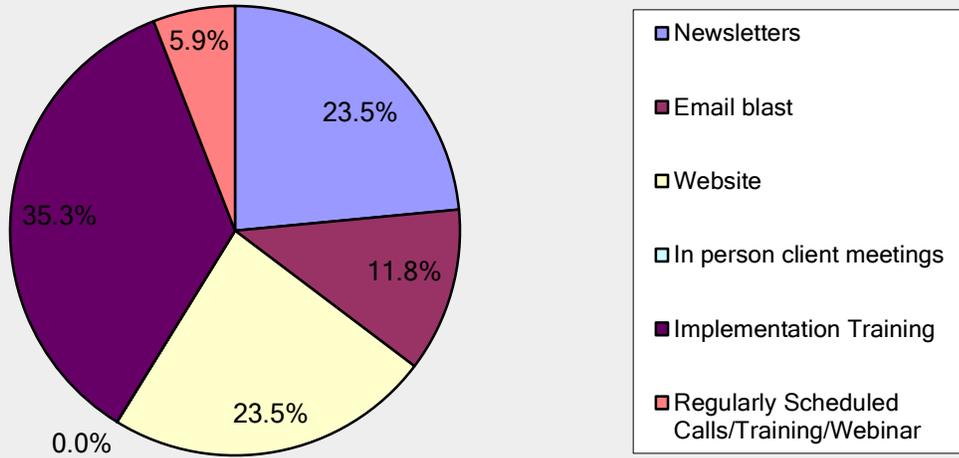
4.5%

22.7%

22.7%

9.1%

4.5%

36.4%
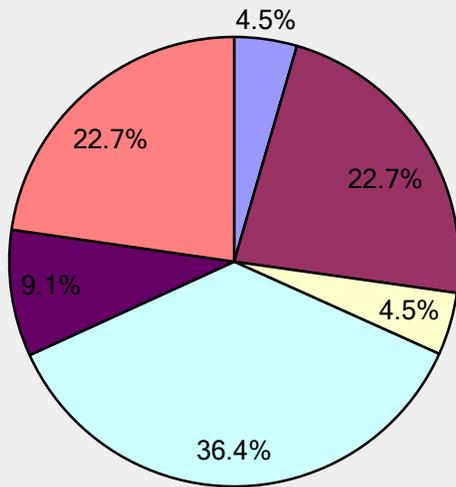
- Verify with ASC X12 by creating an RFI (Request for Information)
- Contact Payer's EDI Helpdesk with RFI information requesting changes to be made by payer
- Return negative acknowledgment
- Notify user
- Both a and b
- All of the above

Q15. Does your system apply business rule logic to reasons and remark codes applied on the electronic remittance advice (i.e., CARCS, RARCS) to automate the provider workflow?
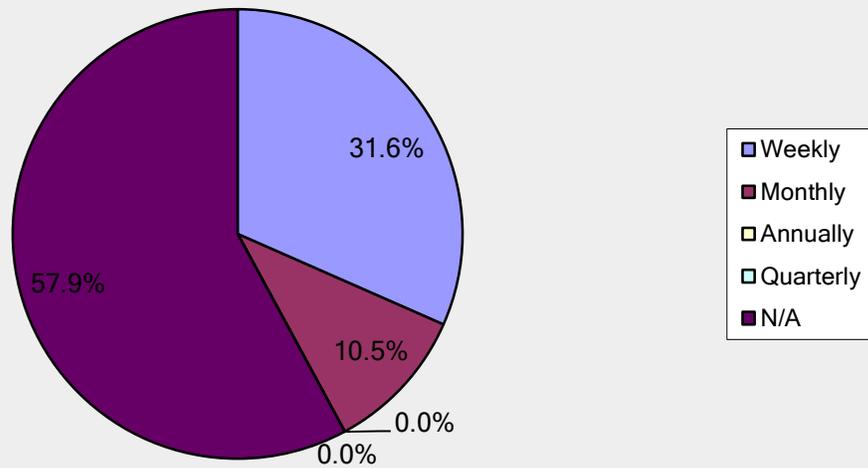
22.7%

13.6%

63.6%
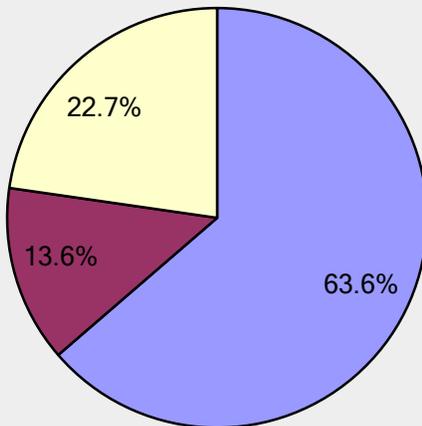
- Yes, all CARC and RARCs
- Yes, only CAQH CORE business rules
- No

## Q16. How does your organization encourage your clients to send and receive EDI standard transactions?

Newsletters: 23.5%
Email blast: 11.8%
Website: 23.5%
In person client meetings: 0.0%
Implementation Training: 35.3%
Regularly Scheduled Calls/Training/Webinar: 5.9%

Legend:
- Newsletters
- Email blast
- Website
- In person client meetings
- Implementation Training
- Regularly Scheduled Calls/Training/Webinar

Q17. How often does your PM encourage your clients to send and receive EDI standard transactions?

Weekly: 31.6%
Monthly: 10.5%
Annually: 0.0%
Quarterly: 0.0%
N/A: 57.9%

Legend:
- Weekly
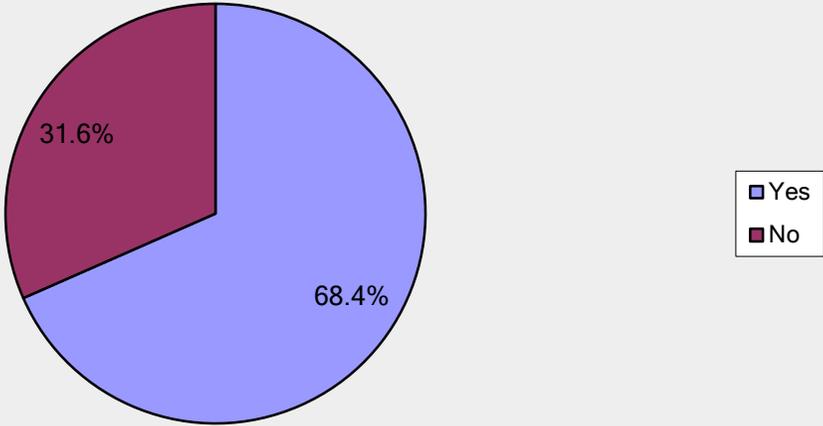- Monthly
- Annually
- Quarterly
- N/A

Q18. Does your system have an automated workflow process for handling primary claims containing standard reductions (deductible, co-pay, co-insurance, exceeds fee schedule)?
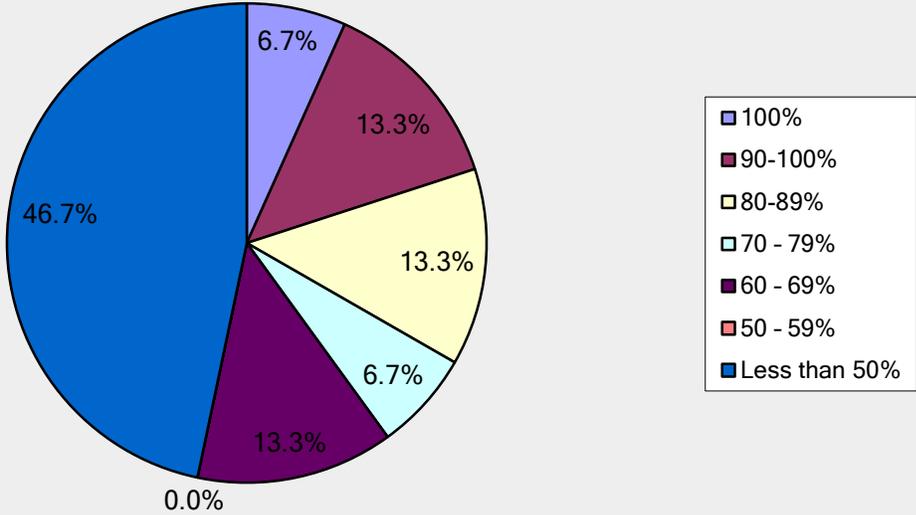
10.5%

89.5%

Yes
No
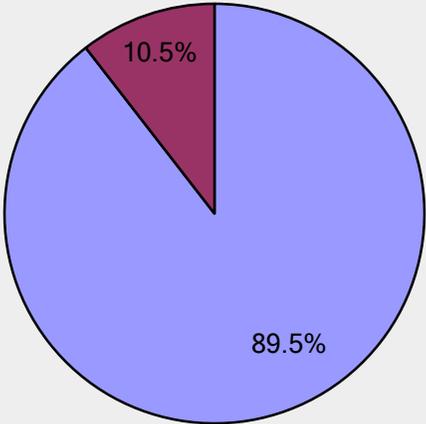
Q19. Does your system have an automated workflow process for handling primary claims containing non-covered services?

26.3%

73.7%

Yes
No
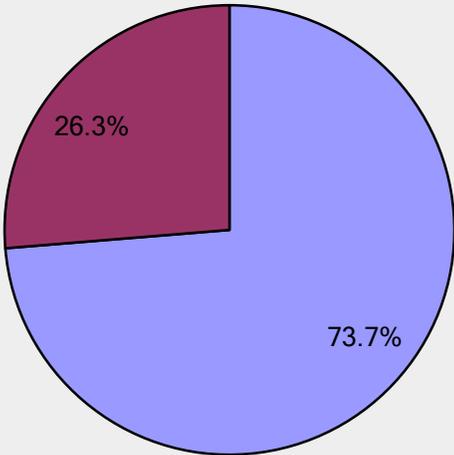
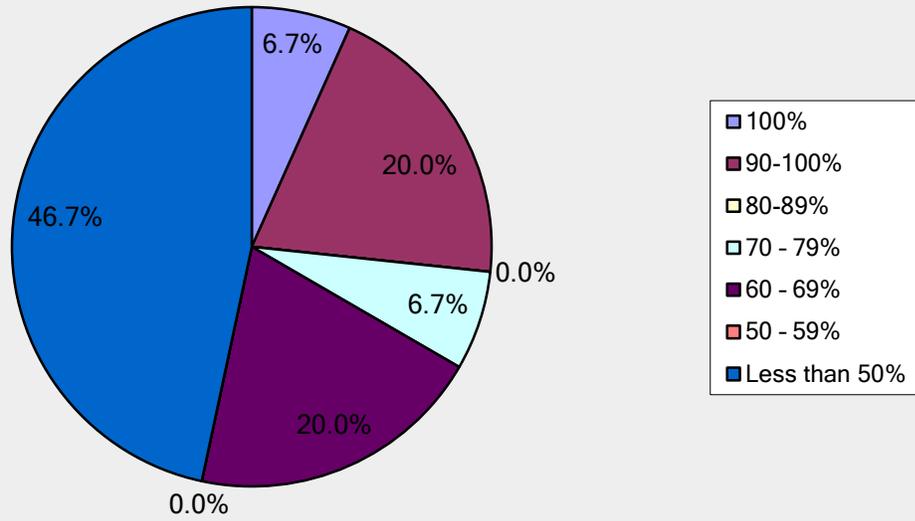## Q20. Does your system have an automated workflow process for handling rejected primary claims requiring additional information?

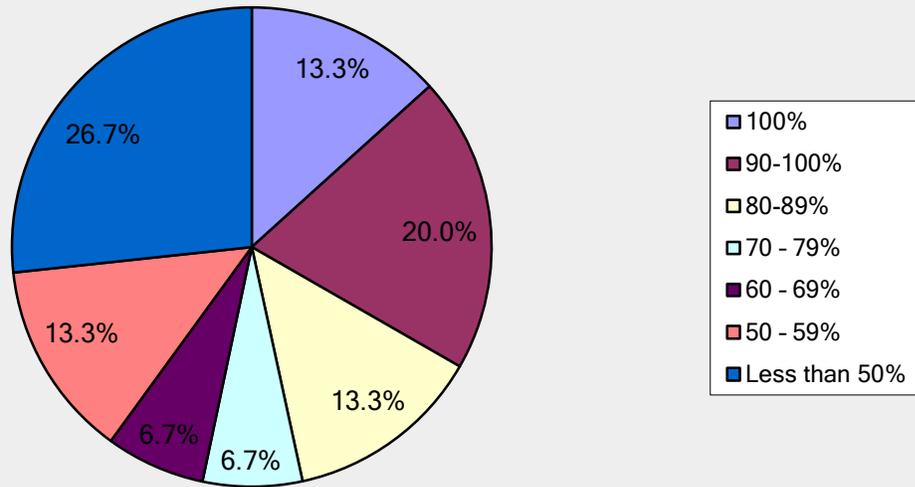|	
☐	Yes
☐	No

31.6%

68.4%

Q 21. Secondary claim payment posting:

6.7%

13.3%

46.7%

13.3%

6.7%

13.3%

0.0%

☐	100%
☐	90-100%
☐	80-89%
☐	70 – 79%
☐	60 – 69%
☐	50 – 59%
☐	Less than 50%

Q22. Automatic submission to secondary/tertiary payers:

6.7%

20.0%

0.0%

6.7%

46.7%

20.0%

0.0%

- ☐ 100%
- ■ 90-100%
- ☐ 80-89%
- ☐ 70 – 79%
- ■ 60 – 69%
- ☐ 50 – 59%
- ■ Less than 50%

Q23. Automatic triggering of patient bills after all payers respond:

13.3%

26.7%

20.0%

13.3%

13.3%

6.7%

6.7%

- ☐ 100%
- ■ 90-100%
- ☐ 80-89%
- ☐ 70 – 79%
- ■ 60 – 69%
- ☐ 50 – 59%
- ■ Less than 50%

Q24. Re-adjudicated claims (reversal and correction) with additional payment:

Legend:
- 100%
- 90-100%
- 80-89%
- 70 – 79%
- 60 – 69%
- 50 – 59%
- Less than 50%

Pie values: 7.1%, 14.3%, 14.3%, 14.3%, 7.1%, 14.3%, 28.6%

Q25. Re-adjudicated claims (reversal and correction) with immediate overpayment recovery:

Legend:
- 100%
- 90-100%
- 80-89%
- 70 – 79%
- 60 – 69%
- 50 – 59%
- Less than 50%

Pie values: 7.1%, 14.3%, 14.3%, 7.1%, 7.1%, 14.3%, 35.7%

Q26. Re-adjudicated claims (reversal and correction) with delayed overpayment recovery:

Legend:
- 100%
- 90-100%
- 80-89%
- 70 - 79%
- 60 - 69%
- 50 - 59%
- Less than 50%

Pie chart values: 6.7%, 6.7%, 26.7%, 20.0%, 0.0%, 6.7%, 33.3%

Q 27. Balance forward:

Legend:
- 100%
- 90-100%
- 80-89%
- 70 - 79%
- 60 - 69%
- 50 - 59%
- Less than 50%

Pie chart values: 13.3%, 6.7%, 13.3%, 20.0%, 0.0%, 6.7%, 40.0%
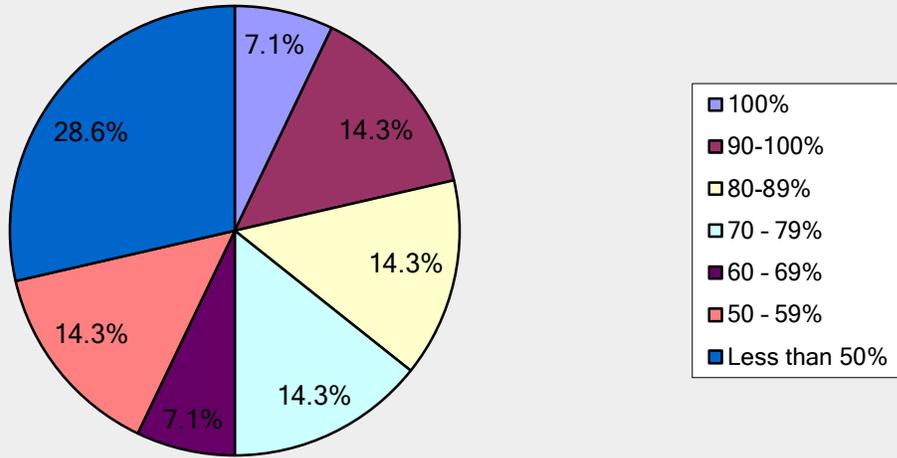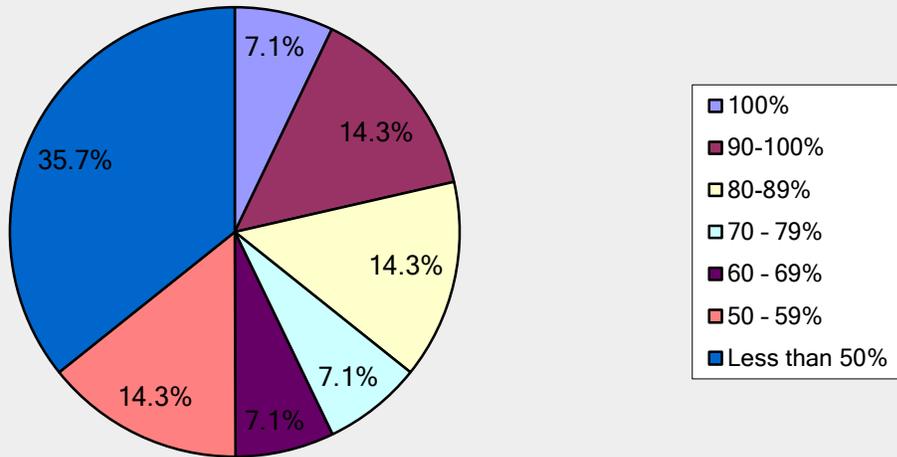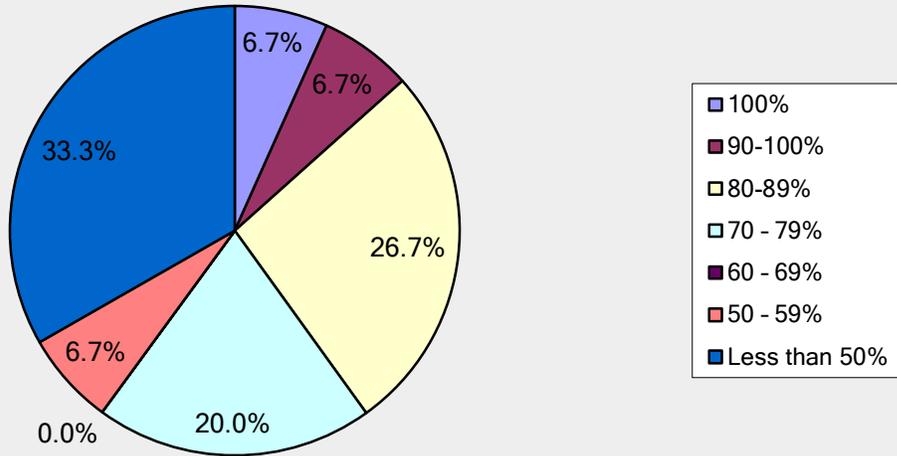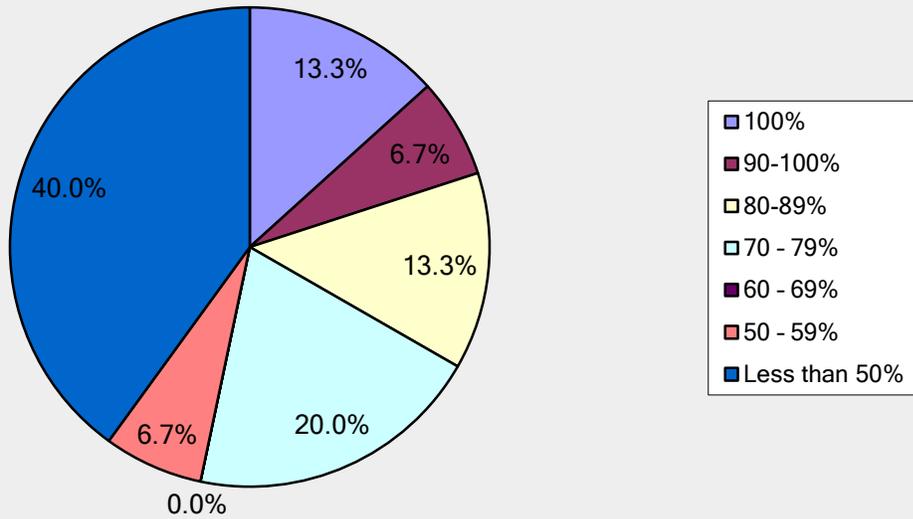
Q28. Overpayment recovery without reversal and correction in the 835:

Legend
100%
90-100%
80-89%
70 - 79%
60 - 69%
50 - 59%
Less than 50%

6.7%
6.7%
33.3%
13.3%
20.0%
20.0%
0.0%

Q. 29 Split claims:

Legend
100%
90-100%
80-89%
70 - 79%
60 - 69%
50 - 59%
Less than 50%

7.1%
14.3%
28.6%
28.6%
7.1%
7.1%
7.1%

Q30. Split services:

Legend:
- 100%
- 90-100%
- 80-89%
- 70 – 79%
- 60 – 69%
- 50 – 59%
- Less than 50%

Values: 7.1%, 7.1%, 28.6%, 7.1%, 14.3%, 14.3%, 21.4%

Q31. Bundled procedures:

Legend:
- 100%
- 90-100%
- 80-89%
- 70 – 79%
- 60 – 69%
- 50 – 59%
- Less than 50%

Values: 7.1%, 21.4%, 21.4%, 7.1%, 0.0%, 0.0%, 42.9%

Q32. Unbundled procedures:

☐	100%
☐	90-100%
☐	80-89%
☐	70 - 79%
☐	60 - 69%
☐	50 - 59%
☐	Less than 50%

- 6.7%
- 6.7%
- 40.0%
- 26.7%
- 6.7%
- 13.3%
- 0.0%

Q33. Managed care encounters:

☐	100%
☐	90-100%
☐	80-89%
☐	70 - 79%
☐	60 - 69%
☐	50 - 59%
☐	Less than 50%

- 7.1%
- 21.4%
- 35.7%
- 14.3%
- 21.4%
- 0.0%
- 0.0%

Q34. Miscellaneous Provider Level Adjustments:

Pie chart showing:
- 13.3% (100%)
- 13.3% (90-100%)
- 13.3% (80-89%)
- 13.3% (70 - 79%)
- 0.0% (60 - 69%)
- 13.3% (50 - 59%)
- 33.3% (Less than 50%)

Legend:
- □ 100%
- ■ 90-100%
- □ 80-89%
- □ 70 - 79%
- ■ 60 - 69%
- ■ 50 - 59%
- ■ Less than 50%

Q35. Does your PM have the capability to automate posting of ASC X12 835s that were converted from a paper EOB to ASC X12 835?

Pie chart showing:
- 50.0%
- 28.6%
- 21.4%

Legend:
- ■ Yes, our PMS is able to auto-post not requiring any manual review
- ■ Yes, our PMS is able to auto-post these types of 835s
- □ No, there are issues related to the accuracy of the data received in the 835s preventing from auto-posting
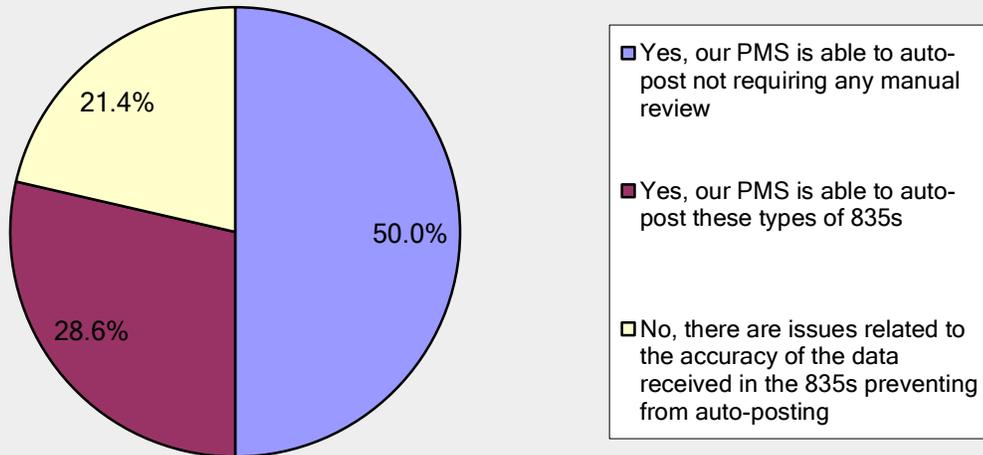
Q39. Can your PMS system automatically post portions of an ASC X12 835 without posting all (i.e. post payments but not adjustments in situations where files are out of balance)?

- 40.0%
- 26.7%
- 20.0%
- 13.3%

Legend:
- Yes, for all Payer's returning an 835
- Yes, for some of the Payer's returning an 835
- No
- Not Applicable
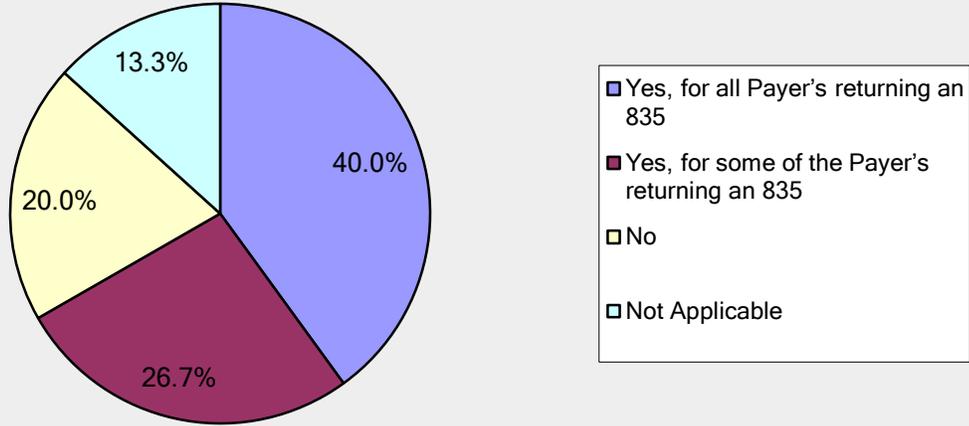
Q40. What percentage of your Providers, accept the healthcare EFT standard via ACH for claims reimbursements other than Medicare?

- 0.0%
- 7.1%
- 7.1%
- 28.6%
- 21.4%
- 0.0%
- 35.7%

Legend:
- 100%
- 90-100%
- 80-89%
- 70 – 79%
- 60 – 69%
- 50 – 59%
- Less than 50%